

Psoriasis

Etiology

- Occurs in 1-3% of US population with world-wide prevalence of 0.1-3% of populations. No gender preference of disease.
- Disease frequently starts between 15-30 years of age. Onset before 10 years of age is rare. Uptodate described bimodal distribution with another peak onset between 50-60 years old.
- Risk factors include: family history associated with some HLA-types, infection, physical or psychological stress, medications (beta blockers, lithium, antimalarials, ACE-I, NSAIDS, terbinafine), smoking, increased BMI.
- Patients often feel embarrassed about lesions and empathy to convey disease is neither repulsive or contagious

Clinical Manifestations

- Skin lesions:
 - Psoriasis lesions begin as red, scaling papules that coalesce to form round to oval plaques, which can easily be distinguished from the surrounding skin.
 - The scale is adherent and silvery white, and reveals bleeding points when removed (Auspitz sign). Scale may become extremely dense, especially on the scalp.
 - Scale forms but is macerated and dispersed in intertriginous areas, which may appear as smooth, red plaques with a macerated surface. Intertriginous type common in gluteal folds.
- Various types of psoriasis have been described: plaque psoriasis, guttate, inverse, nail, pustular, erythrodermic. Most common is plaque psoriasis (70-80%.) Rare but life threatening forms include pustular psoriasis and erythrodermic psoriasis.
- Most commonly affects scalp, elbows and knees, hands, feet, trunk, and nails. Psoriatic arthritis occurs in 10-25% of patients.
- Psoriasis in HIV-infected patients frequently is severe, with palmar and plantar involvement, nail disease, arthritis, and widespread erythrodermic disease.
- Psoriatic arthritis – seronegative spondyloarthropathies that include ankylosing spondylitis and reactive arthritis. Can present as distal arthropathies (DIP's), asymmetric oligoarthritis, symmetric polyarthritis, arthritis mutilans, spondyloarthropathy.



Treatment

- Mild to Moderate Disease
 - Topical steroids and emollients
 - Desonide (equiv hydrocortisone 2.5%) -> triamcinolone -> lidex -> clobetasone.
 - Alternatives: calcipotriene (Dovonex), tar, topical retinoids, topical calcineurin inhibitors (facial and intertriginous), and UVB therapy
 - May see results within 1 week but often require several weeks of treatment.
- Severe Disease
 - Combination of phototherapy and systemic therapies. Grade 2B recommendation for initiating phototherapy first.
 - Systemic therapies include: retinoids, methotrexate, cyclosporine, and biologic immune agents such as alefacept, adalimumab, etanercept, infliximab, and ustekinumab.

Patient Resource

- National Psoriasis Foundation (<http://www.psoriasis.org>)